OPTUM® Idaho Behavioral Health Plan

# Presumptive/Qualitative Drug Testing Service Request Form

## Medicaid Participant Information

First Name: Middle Initial: Last Name:

Medicaid ID: Date of Birth: Age: _____ Phone:

Parent/Guardian Name: Parent/Guardian Phone:

## Requesting Provider Information

Provider First Name: Provider Last Name:

Provider Credentials: Provider E-mail:

Provider NPI#: Phone: Fax:

Agency Name: Tax ID#:

Address: Suite#:

City: State: Zip Code:

## Service Request Information

This provider recommends 12 units of Drug Testing for the remainder of the year: ◯ YES ◯ NO

If NO, how many units are you requesting for the remainder of the year?

Requested Start Date for this authorization:

## Reason for Request

**Select as many of the following statements that apply to member:**

☐ The member is participating in Substance Use Disorder Treatment.

☐ The member is being assessed for possible Substance Use Disorder.

☐ The member has an altered mental status.

☐ The member has a possible overdose.

☐ The member has had multiple relapses in the past calendar year, requiring multiple treatment starts and episodes of frequent testing.

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## Reason For Request (continued)

**Why are additional units being requested?** Describe the evidence-based services that member is receiving and describe member's engagement in treatment. (Max 1000 characters.)

What level of treatment is member engaged in?

Date of member's last relapse:

## Diagnosis Information

**Does the member have a behavioral health diagnosis?** ◯ YES ◯ NO

If YES, below note the PRIMARY diagnosis first, then include any additional diagnoses.

| **Diagnosis Code** *ICD10 or DSM-V* | **DSM-5 Diagnosis Name** |
|---|---|

If **NO**, is the member being assessed for a behavioral health diagnosis? ◯ YES ◯ NO

## Form Submission

**Please sign and submit via e-mail to optum_idaho_auths@optum.com, or by fax to (855) 708-9282.**

**Thank you.**

**Requester Signature:** **Date:**